General Assembly

Substitute Bill No. 813

January Session, 2015

AN ACT CONCERNING HEALTH CARE PRICE, COST AND QUALITY TRANSPARENCY.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-1084 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

The exchange shall:

(1) Administer the exchange for both qualified individuals and qualified employers;

(2) Commission surveys of individuals, small employers and health care providers on issues related to health care and health care coverage;

(3) Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under Section 1311(c) of the Affordable Care Act, and section 38a-1086, of health benefit plans as qualified health plans;

(4) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(5) Provide for enrollment periods, as provided under Section 1311(c)(6) of the Affordable Care Act;

(6) (A) Maintain an Internet web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans including, but not limited to, the enrollee satisfaction survey information under Section 1311(c)(4) of the Affordable Care Act and any other information or tools to assist enrollees and prospective enrollees evaluate qualified health plans offered through the exchange, and (B) establish and maintain a consumer health information Internet web site, as described in section 2 of this act;

(7) Publish the average costs of licensing, regulatory fees and any other payments required by the exchange and the administrative costs of the exchange, including information on moneys lost to waste, fraud and abuse, on an Internet web site to educate individuals on such costs;

(8) On or before the open enrollment period for plan year 2017, assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the Secretary under Section 1311(c)(3) of the Affordable Care Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under Section 1302(d)(2)(A) of the Affordable Care Act;

(9) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under Section 2715 of the Public Health Service Act, 42 USC 300gg-15, as amended from time to time;

(10) Inform individuals, in accordance with Section 1413 of the Affordable Care Act, of eligibility requirements for the Medicaid program under Title XIX of the Social Security Act, as amended from time to time, the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, as amended from time to time, or any applicable state or local public program, and enroll an individual in such program if the exchange determines, through screening of the

application by the exchange, that such individual is eligible for any such program;

(11) Collaborate with the Department of Social Services, to the extent possible, to allow an enrollee who loses premium tax credit eligibility under Section 36B of the Internal Revenue Code and is eligible for HUSKY Plan, Part A or any other state or local public program, to remain enrolled in a qualified health plan;

(12) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code and any cost-sharing reduction under Section 1402 of the Affordable Care Act;

(13) Establish a program for small employers through which qualified employers may access coverage for their employees and that shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the exchange at the specified level of coverage;

(14) Offer enrollees and small employers the option of having the exchange collect and administer premiums, including through allocation of premiums among the various insurers and qualified health plans chosen by individual employers;

(15) Grant a certification, subject to Section 1411 of the Affordable Care Act, attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code, an individual is exempt from the individual responsibility requirement or from the penalty imposed by said Section 5000A because:

(A) There is no affordable qualified health plan available through the exchange, or the individual's employer, covering the individual; or

(B) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(16) Provide to the Secretary of the Treasury of the United States the following:

(A) A list of the individuals granted a certification under subdivision (15) of this section, including the name and taxpayer identification number of each individual;

(B) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code because:

(i) The employer did not provide minimum essential health benefits coverage; or

(ii) The employer provided the minimum essential coverage but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code to be unaffordable to the employee or not provide the required minimum actuarial value; and

(C) The name and taxpayer identification number of:

(i) Each individual who notifies the exchange under Section 1411(b)(4) of the Affordable Care Act that such individual has changed employers; and

(ii) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(17) Provide to each employer the name of each employee, as described in subparagraph (B) of subdivision (16) of this section, of the employer who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(18) Perform duties required of, or delegated to, the exchange by the Secretary or the Secretary of the Treasury of the United States related to determining eligibility for premium tax credits, reduced cost-

sharing or individual responsibility requirement exemptions;

(19) Select entities qualified to serve as Navigators in accordance with Section 1311(i) of the Affordable Care Act and award grants to enable Navigators to:

(A) Conduct public education activities to raise awareness of the availability of qualified health plans;

(B) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under Section 36B of the Internal Revenue Code and cost-sharing reductions under Section 1402 of the Affordable Care Act;

(C) Facilitate enrollment in qualified health plans;

(D) Provide referrals to the Office of the Healthcare Advocate or health insurance ombudsman established under Section 2793 of the Public Health Service Act, 42 USC 300gg-93, as amended from time to time, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint or question regarding the enrollee's health benefit plan, coverage or a determination under that plan or coverage; and

(E) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;

(20) Review the rate of premium growth within and outside the exchange and consider such information in developing recommendations on whether to continue limiting qualified employer status to small employers;

(21) Credit the amount, in accordance with Section 10108 of the Affordable Care Act, of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled and collect the amount credited from the offering employer;

(22) Consult with stakeholders relevant to carrying out the activities required under sections 38a-1080 to 38a-1090, inclusive, including, but not limited to:

(A) Individuals who are knowledgeable about the health care system, have background or experience in making informed decisions regarding health, medical and scientific matters and are enrollees in qualified health plans;

(B) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) Representatives of small employers and self-employed individuals;

(D) The Department of Social Services; and

(E) Advocates for enrolling hard-to-reach populations;

(23) Meet the following financial integrity requirements:

(A) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the Secretary, the Governor, the Insurance Commissioner and the General Assembly a report concerning such accountings;

(B) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Affordable Care Act and allow the Secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

(i) Investigate the affairs of the exchange;

(ii) Examine the properties and records of the exchange; and

(iii) Require periodic reports in relation to the activities undertaken by the exchange; and

(C) Not use any funds in carrying out its activities under sections 38a-1080 to 38a-1089, inclusive, and section 38a-1091 that are intended for the administrative and operational expenses of the exchange, for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or state legislative and regulatory modifications;

(24) Seek to include the most comprehensive health benefit plans that offer high quality benefits at the most affordable price in the exchange;

(25) Report at least annually to the General Assembly on the effect of adverse selection on the operations of the exchange and make legislative recommendations, if necessary, to reduce the negative impact from any such adverse selection on the sustainability of the exchange, including recommendations to ensure that regulation of insurers and health benefit plans are similar for qualified health plans offered through the exchange and health benefit plans offered outside the exchange. The exchange shall evaluate whether adverse selection is occurring with respect to health benefit plans that are grandfathered under the Affordable Care Act, self-insured plans, plans sold through the exchange and plans sold outside the exchange; and

(26) Seek funding for and oversee the planning, implementation and development of policies and procedures for the administration of the all-payer claims database program established under section 38a-1091.

Sec. 2. (NEW) (*Effective October 1, 2015*) (a) For purposes of this section:

(1) "Allowed amount" means the maximum reimbursement dollar amount that an insured's health insurance policy allows for a specific procedure or service;

(2) "Episode of care" means all health care services related to the treatment of a condition and, for acute conditions, includes health care services and treatment provided from the onset of the condition to its

resolution and, for chronic conditions, includes health care services and treatment provided over a given period of time.

(3) "Exchange" means the Connecticut Health Insurance Exchange established pursuant to section 38a-1081 of the general statutes;

(4) "Health care provider" means any individual, corporation, facility or institution licensed by this state to provide health care services;

(5) "Health carrier" means any insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing any individual or group health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes;

(6) "Hospital" has the same meaning as provided in section 19a-490 of the general statutes;

(7) "Out-of-pocket cost" means costs that are not reimbursed by a health insurance policy and includes deductibles, coinsurance and copayments for covered services and other costs to the consumer associated with a procedure or service;

(8) "Outpatient surgical facility" has the same meaning as provided in section 19a-493b of the general statutes; and

(9) "Public or private third party" means the state, the federal government, employers, a health carrier, third-party administrator or managed care organization.

(b) (1) The exchange shall establish a consumer health information Internet web site to assist consumers in making informed decisions concerning their health care and informed choices among health care providers. Such Internet web site shall: (A) Contain information comparing the quality, price and cost of health care services, including,

to the extent practicable (i) comparative price and cost information for the most common referrals or prescribed services categorized by payer and listed by facility, health care provider and provider organization, (ii) comparative quality information by facility, health care provider, provider organization or any other provider grouping for each service or category of services for which comparative price and cost information is provided, (iii) data concerning health care-associated infections and serious reportable events, (iv) definitions of common health insurance and medical terms, as determined by the Insurance Commissioner pursuant to section 6 of this act, so consumers may compare health coverage and understand the terms of their coverage, (v) a list of health care provider types, including primary care physicians, nurse practitioners and physician assistants and the types of services each type of health care provider is authorized to provide, (vi) factors consumers should consider when choosing an insurance product or provider group, including provider network, premium, cost-sharing, covered services and tier information, (vii) patient decision aids, (viii) a list of provider services that are physically and programmatically accessible for persons with disabilities, and (ix) descriptions of standard quality measures; (B) be designed to assist consumers and institutional purchasers in making informed decisions regarding their health care and informed choices among health care providers and allows comparisons between prices paid by various health carriers to health care providers; (C) present information in language and a format that is understandable to the average consumer; and (D) be publicized to the general public. All information received by the exchange pursuant to the provisions of this section shall be posted on the Internet web site.

(2) Information collected, stored and published by the exchange pursuant to this section is subject to the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time. Any individually identifiable health information shall be secure, encrypted, as necessary, and shall not be disclosed.

(c) Not later than October 1, 2016, and annually thereafter, the Insurance Commissioner and the Commissioner of Public Health shall jointly report to the exchange and make available to the public on the Insurance Department's and Department of Public Health's Internet web sites: (1) The one hundred most frequently provided inpatient admissions in the state, (2) the one hundred most frequently provided outpatient procedures performed in the state, (3) the twenty-five most frequent surgical procedures performed in the state, and (4) the twenty-five most frequent imaging procedures performed in the state. Such lists contained in the report may include bundled episodes of care. At the request of the exchange, such lists may be expanded to include additional admissions and procedures.

(d) Not later than January 1, 2016, and annually thereafter, each health carrier shall submit to the exchange the (1) allowed amounts paid to health care providers in the health carrier's network for each admission and procedure included in the report submitted to the exchange by the commissioners pursuant to subsection (c) of this section, and (2) out-of-pocket costs for each such admission and procedure.

(e) Not later than January 1, 2016, and annually thereafter, each hospital and outpatient surgical facility shall report to the exchange the following information for each admission and procedure reported in accordance with subsection (c) of this section: (1) The amount to be charged to a patient for each such admission or procedure if all charges are paid in full without a public or private third party paying any portion of the charges, (2) the average negotiated settlement on the amount to be charged to a patient as described in subdivision (1) of this subsection, (3) the amount of Medicaid reimbursement for each such admission or procedure, including claims and pro rata supplement payments, (4) the amount of Medicare reimbursement for each such admission or procedure, and (5) for the five largest health carriers according to the previous year's patient volume, the allowed amount for each such admission or procedure, with the health carriers

names and other identifying information redacted. Notwithstanding the provisions of this subsection, a hospital or outpatient surgical facility shall not report information that may reasonably lead to the identification of individuals admitted to, or who receive services from, the hospital or outpatient surgical facility.

(f) Each hospital and outpatient surgical facility shall, not later than two business days after scheduling an admission, procedure or service included in the report submitted to the exchange by the Insurance Commissioner and the Commissioner of Public Health pursuant to subsection (c) of this section, provide written notice to the patient that is the subject of the admission or procedure concerning: (1) If the patient is uninsured, the amount to be charged for the admission or procedure if all charges are paid in full without a public or private third party paying any portion of the charges, including the amount of any facility fee, or, if the hospital or outpatient surgical facility is not able to provide a specific amount due to an inability to predict the specific treatment or diagnostic code, the estimated maximum allowed amount or charge for the admission or procedure, including the amount of any facility fee; (2) the Medicare reimbursement amount; (3) if the patient is insured, the allowed amount, the toll-free telephone number and the Internet web site address of the patient's health carrier where the patient can obtain information concerning charges and out-of-pocket expenses; (4) The Joint Commission's composite accountability rating for the hospital or outpatient surgical facility; and (5) the Internet web site addresses for The Joint Commission and the Medicare Hospital Compare tool where the patient may obtain information concerning the hospital or outpatient surgical facility.

(g) The Commissioner of Public Health, in consultation with the Insurance Commissioner and the Healthcare Advocate, shall (1) develop quality measures for health carriers to include when providing information to patients concerning the costs of health care services, and (2) determine quality measures to be reported by health carriers and health care providers to the exchange. In developing such

measures, said commissioners and the Healthcare Advocate shall consider those quality measures recommended by the National Quality Forum's Measures Applications Partnership and the National Priorities Partnership.

(h) The Commissioner of Social Services shall submit to the exchange all Medicaid data requested for the all-payer claims database, established pursuant to section 38a-1091 of the general statutes.

Sec. 3. (NEW) (*Effective October 1, 2015*) (a) For purposes of this section, "health care provider" means any person, corporation, facility or institution licensed by this state to provide health care services.

(b) Each health care provider shall, at the time such health care provider schedules an admission or procedure for a patient, determine whether the patient is covered under a health insurance policy. If the patient is determined to be covered under a health insurance policy, the health care provider shall notify the patient, in writing, as to whether the health care provider is in-network or out-of-network under such policy and provide the toll-free telephone number and Internet web site address of the patient's health carrier. If the patient is determined not to have health insurance coverage or the patient's health care provider is out-of-network, the health care provider shall notify the patient in writing (1) of the actual charges for the admission or procedure, and (2) that such patient may be charged, and is responsible for payment for unforeseen services that may arise out of the proposed admission or procedure. Nothing in this subsection shall prevent a health care provider from charging a patient for such unforeseen services.

(c) Each health care provider that refers a patient to another health care provider that is part of, or represented by, the same provider organization shall notify the patient, in writing, that the health care providers are part of, or represented by, the same provider organization.

(d) Each health care provider and health carrier shall ensure that any billing statement or explanation of benefits submitted to a patient or insured is written in language that is understandable to an average reader.

Sec. 4. (NEW) (*Effective October 1, 2015*) (a) For purposes of this section, (1) "health care provider" means any individual, corporation, facility or institution licensed by this state to provide health care services, and (2) "health carrier" means any insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing any individual or group health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes.

(b) On and after October 1, 2015, no contract entered into, or renewed, between a health care provider and a health carrier shall contain a provision prohibiting disclosure of negotiated pricing information, including, but not limited to, pricing information relating to out-of-pocket expenses.

Sec. 5. (NEW) (*Effective October 1, 2015*) (a) For purposes of this section:

(1) "Allowed amount" means the maximum reimbursement dollar amount that an insured's health insurance policy allows for a specific procedure or service;

(2) "Health care provider" means any individual, corporation, facility or institution licensed by this state to provide health care services;

(3) "Health carrier" means any insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing any individual or group health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)

of section 38a-469 of the general statutes and

(4) "Out-of-pocket cost" means costs that are not reimbursed by a health insurance policy and includes deductibles, coinsurance and copayments for covered services and other costs to the consumer associated with a procedure or service.

(b) Each health carrier shall develop and publish an Internet web site and institute the use of a mobile device application and toll-free telephone number that enables consumers to request and obtain: (1) Information on in-network costs for inpatient admissions, health care procedures and services, including (A) the allowed amount for (i) at a minimum, admissions and procedures reported to the Connecticut Health Insurance Exchange pursuant to section 2 of this act for each health care provider in the state, and (ii) prescribed drugs and durable medical equipment; (B) the estimated out-of-pocket cost that the consumer would be responsible for paying for any such admission or procedure that is medically necessary, including any facility fee, copayment, deductible, coinsurance or other expense; and (C) data or other information concerning (i) quality measures for the health care provider, as such measures are determined by the Commissioner of Public Health in accordance with subsection (g) of section 2 of this act, (ii) patient satisfaction, (iii) whether a health care provider is accepting new patients, (iv) credentials of health care providers, (v) languages spoken by health care providers, and (vi) network status of health care providers; and (2) information on out-of-network costs for inpatient admissions, health care procedures and services. Each health carrier shall use on its Internet web site the defined terms established by the Insurance Commissioner pursuant to section 6 of this act.

(c) A health carrier shall not require a consumer to pay a higher amount for an inpatient admission, health care procedure or service than that disclosed to the consumer pursuant to subsection (b) of this section, provided a health carrier may impose additional cost-sharing requirements for unforeseen services that arise out of the proposed admission or procedure if (1) such requirements are disclosed in the

health benefit plan, and (2) the health carrier advised the consumer when providing the cost-sharing information that the amounts are estimates and that the consumer's actual cost may vary due to the need for unforeseen services that arise out of the proposed admission or procedure.

(d) Each health carrier shall submit to the Insurance Commissioner not later than July 1, 2016, and annually thereafter, a detailed description of (1) the manner in which cost-sharing information is communicated to consumers, as required pursuant to subsection (b) of this section, (2) any marketing efforts undertaken to inform consumers of the information available pursuant to the provisions of this section, (3) any surveys of consumers conducted to determine consumer satisfaction with the manner in which cost-sharing information is communicated, and (4) the tools used to provide cost-sharing information to consumers.

(e) Not later than thirty days after the date that a health care provider stops accepting patients who are enrolled in an insurance plan, such health care provider shall notify, in writing, the applicable health carrier.

Sec. 6. (NEW) (*Effective October 1, 2015*) The Insurance Commissioner shall establish standard terms with definitions to be used by health carriers and health care providers for the purposes of complying with sections 2, 3 and 5 of this act, to ensure consumers obtain accurate, relevant and complete price information.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2015*	38a-1084
Sec. 2	*October 1, 2015*	New section
Sec. 3	*October 1, 2015*	New section
Sec. 4	*October 1, 2015*	New section
Sec. 5	*October 1, 2015*	New section
Sec. 6	*October 1, 2015*	New section

PH *Joint Favorable Subst. -LCO*

INS *Joint Favorable*

APP *Joint Favorable*